STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155159	A. BUILDING 00 B. WING	01/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT CITY NURSING AND REHABILITATION	2940 N CLINTON ST FORT WAYNE, IN 46805

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F0000	This visit was for the Investigation of Complaint IN00101632. This visit resulted in a partially extended survey - Immediate Jeopardy. Complaint IN00101632: Substantiated, Federal/State deficiencies related to the allegation are cited at F323, F250 and F514. Survey dates: 12/30, 12/31/11 and 1/1/12 Extended date 1/3/12 Facility number: 000079 Provider number: 155159 Aim number: 100266160 Survey team: Ellen Ruppel, RN TC Ann Armey, RN Census bed type: SNF/NF: 49 Total: 49	F0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post survey review on or after 1-27-12.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Census payor type: Medicare: 4 Medicaid: 37 Other: 8 Total: 49 Sample: 5 Supplemental sample: 2 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 1/4/12 Cathy Emswiller RN			

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F0250 SS=D	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to comprehensively assess a resident's behaviors. This deficiency affected 1 of 3 residents, whose behavioral tracking records were reviewed, in a sample of 5. (Resident #C) Findings include: On 12/30/11 at 12:00 noon, during the orientation tour, the DON (Director of Nursing) indicated Resident #C had been involved in an altercation on the Alzheimer's Unit and had been hospitalized in a behavioral unit. The DON indicated Resident #C had returned to the facility following her stay at the behavioral unit. On 12/30/11 at 1:30 p.m., the Memory Care Facilitator indicated behaviors were documented on pink behavior tracking records, and	F0250	**250 Provision of medically related Social Services.** It is the practice of this provider to provide medically related Social Services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident "C" care plan and behavior plan has been updated to reflect resident's current status. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents experiencing behaviors at the facility have the potential to be affected by the alleged deficient practice. · Staff will be re-educated on the facility behavior program by the Director of Nursing or designee by 1-24-12. · Care plans and behavior plans have been updated for all residents on the Augustes Cottage. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · .Staff will be re-educated on the facility behavior program by the Director of Nursing or	01/27/2012

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	were reviewed by the IDT (Interdisciplinary Team). The Memory Care Facilitator indicated, if there was a new or significant behavior, the resident's care plan was updated, an interdisciplinary note was made, the individual's behavior tracking records were then placed in the clinical record and a summary of each resident's behaviors was completed each month. The clinical record of Resident #C was reviewed on 12/30/11 at 2:00 p.m., and indicated the resident was admitted to the facility on 6/9/05 with diagnoses which included but were not limited to, vascular dementia with delusions and depression. Resident #C was hospitalized in a behavioral unit on 12/3/11 and returned to the facility on 12/19/11. Resident #C had ten behaviors documented on the behavior tracking records between 9/7/11 and 12/30/11. Factors causing the		designee by 1-24-12. · Residents admitting to the facility with behaviors will have a behavior plan developed. · Residents care plan and behavior plans will be updated with interventions for staff to utilize in the event of a behavior by SSD and/or IDT. Interventions have been added to the C.N.A. Assignment Sheets) · Staff will complete a behavior-tracking sheet with each behavior. · The tracking sheet will address what caused the behavior, what type of behavior, staff intervention, and if the intervention was effective. · Social Services and / or designee will review behavior sheets daily to ensure thoroughness and completeness. · New or worsening behaviors will be reviewed by IDT Monday through Friday, weekends will call the on-call Nurse to assess for cause, and ensure to update interventions to decrease cause. · Outside Psych Services are provided for residents with behaviors. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · A "Psychoactive Medications/Behavior Management"CQI tool will be utilized weekly x 4, then monthly thereafter by the SSD or designee for 6 months. · Data will be submitted to the CQI Committee for review and follow	

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	behavior, location of the incident and staff interventions were not documented on four of the ten behavior tracking forms, as follows: On 9/9/11 at 11:15 a.m., Resident #C threw her salad across the floor. The location of the incident, causative factors and staff interventions were not documented on the form. On 10/17/11 at 3:15 p.m., Resident #C "got upset and threw the jingo chips." Staff interventions at the time of the incident were not documented on the form. On 11/2/11 at 8:40 a.m., the resident was verbally aggressive with another resident. The causative factors were not documented on the form. On 11/17/11 at 12:15 p.m., "she was taking up for the res (resident) that could not take up for herself." The type of behavior, causative factors, and location of the incident were not documented on the form. During interview on 1/1/12 at 1:30 p.m., the Memory Care Coordinator		up. Non-compliance may result in disciplinary action up to and including termination. If threshold of 90% is not met, an action plan will be developed. · The Director of Nursing Services is responsible to monitor for program compliance. **Compliance date: 1-27-12.**	

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	indicated the Behavior Tracking Records were not filled out completely and they should have been. The Behavior Management Policy and Procedure (undated), provided by the Director of Nursing was reviewed on 1/1/12 at 1:45 p.m. and indicated "...6. When a behavior occurs, the staff fill out a Behavior Sheet....Any staff member can fill out a behavior sheet indicating a description of the behavior, the location of the behavior, any precipitating events, what interventions they attempted during the episode and whether or not they were effective." This Federal tag relates to Complaint IN00101632. 3.1-34(a)			

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F0323 SS=K	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interviews and record review, the facility failed to provide supervision to prevent falls and prevent a resident altercation which resulted in a fall, injury, hospitalization and death. This deficiency affected 1 of 4 residents in a sample of 5 reviewed, who was injured during a fall/altercation (Resident B) by the actions of a second resident (Resident C). This deficient practice had the potential to affect 26 of 26 residents living on the Alzheimer's/dementia Unit. (Resident B, D, E and C) This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 12/30/11 at 4:30 p.m., and began on 12/1/11, when Resident B sustained an unwitnessed fall in the dining/activity area of the secured unit of the facility. The Administrator, Corporate Director	F0323	**323 Accidents and supervision** It is the practice of this provider to ensure the resident's environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident "B" no longer resides at the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · Residents residing in the facility have the potential to be affected by the alleged deficient practice. · Staff will be re-educated on supervision of residents to include falls, behavior and activities. This in-service will be conducted by the Director of Nursing and/or designee on 1-24-12. · Staff member will be in dining room / common area at all times when more than one resident is in the room (until such time as the	01/27/2012

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	of Operations, Clinical Care Specialist, Social Service Director and Director of Nursing were notified of the Immediate Jeopardy on 12/30/11 at 4:30 p.m. The Immediate Jeopardy was removed on 12/31/11, but the facility remained out of compliance at the level of pattern with potential for more than minimal harm that is not immediate jeopardy because of inservicing of staff, evaluation of the activity program and monitoring the presence of staff at all times in the hallways, dining and common areas. Findings include: On 12/30/11 at 12:00 noon, during the orientation tour, the Director of Nursing (DON) indicated Resident #C had been involved in an altercation with another resident on the secured dementia unit. The DON indicated, after the incident, Resident #C had been hospitalized in a behavioral unit, and had returned to the facility.		planned remodel of the nurse's station is complete allowing improved monitoring of the dining room/common area).This staff member will assist in providing activities, movies, as well as overall monitoring of residents. · A new Supervisor schedule has been developed to cover each shift of the dining room / common area. · Nurse Manager's office moved to dining / common room area. · Walkie-talkies purchased to enhance communication. Staff will maintain a walkie-talkie with them during hours of supervision. Staff will utilize walkie-talkie for communication as needed. Charge Nurse on duty will carry one walkie-talkie at all times. · Activity Program has been restructured to provide alternating active and passive activities. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Staff will be re-educated on supervision of residents to include falls, behaviors and activities. This in-service will be conducted by the Director of Nursing and/or designee by 1-24-12. · The facility will continue to provide a home like environment that maximizes dignity, productivity, quality of life and safety to residents residing in the facility. This corrective action will be monitored by the DNS. · A	

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	The resident was observed sitting in a wheelchair in the dining/activity area of the secured unit, with other residents and staff members present. Residents were just finishing the noon meal. The clinical record of Resident C was reviewed on 12/30/11 at 2:00 p.m. and indicated the resident was admitted to the facility on 6/9/05 with diagnoses which included but were not limited to, vascular dementia with delusions and depression. The resident was admitted to a behavioral unit on 12/3/11 and returned to the facility on 12/19/11. Her return diagnoses included dementia with delusions and depression. A care plan, initiated on 7/25/11, indicated Resident C had "...episodes of combative behavior like hitting others." The Minimum Data Set		Supervisor Schedule has been developed to cover supervision of the dining / common area by staff for each shift. · Nurse Manager's office has been moved to the dining / common area until construction is complete on the new Nurse's Station. Nursing staff will continue to monitor the area when more than 1 one resident is in the room, once construction is complete. · Staff will observe residents for gait / unsteadiness and intervene as necessary. · Staff will stay with residents that have experienced a fall and utilize the walkie-talkie to call for assistance. · Staff will observe for resident behaviors / interactions and intervene as necessary utilizing updated care plans and C.N.A Assignment Sheets. IDT will ensure care plans and C.N.A. Assignment Sheets are updated as needed. · Staff will ensure residents safety and utilize the walkie-talkie to call for assistance. · Facility will continue to provide ongoing active and passive activities to meet the interests and physical, mental and psychosocial well being of each resident. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A “Fall Management”CQI tool will be utilized weekly x 4, then monthly thereafter. This tool will be completed by Nurse Manager	

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	Assessment, dated 10/19/11, indicated the resident had severe cognitive impairments. Interdisciplinary notes, dated 10/13/11, indicated, during breakfast at 8:25 a.m., the resident hit Resident E in the right upper arm, when Resident E leaned over her. The incident was witnessed by staff, who were present in the dining room. Resident C was placed on fifteen minute checks and received an initial behavioral psychiatric assessment on 10/14/11. The Psychiatric Nurse Practitioner saw her again on 11/24/11, and wrote in the problem area of the note "Staff asked I see resident 2 (secondary to) increase (sic) behaviors, irritability, and potential risk of resident harming other (sic)." The Nurse Practitioner also ordered Abilify 5 mg daily (an anti-psychotic medication). Nursing notes, dated 12/3/11 at 10:20 a.m., indicated Resident C		and/ or SSD for 6 months. · Data will be submitted to the CQI Committee for review and follow up. Non-compliance may result in disciplinary action up to and including termination. If threshold is less than 90% an action plan will be developed. · The Executive Director and/or designee is responsible to monitor for program compliance. **Compliance Date: 1-27-12.**	

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	was involved in a second altercation with two residents. The note indicated a resident witnessed Resident C push Resident B down. The facility incident report form, for the incident on 12/3/11, indicated Resident C, Resident B and Resident D were in the main dining room on the Alzheimer's Unit, when staff heard yelling. Upon entering the dining room, Resident B was on the floor and Resident C had Resident B's walker and was attempting to swing it at Resident D, who was hitting Resident C. The report indicated Resident B was injured and had sustained a hematoma on the back of her head. Review of the closed clinical record of Resident B, on 12/30/11 at 2:00 p.m., indicated she had been admitted to the facility on 3/11/09, with diagnoses including, but not limited to: dementia, hypertension and cardiac arrhythmia. The Minimum Data Set (MDS)			

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	assessment, dated 10/31/11, indicated the facility was unable to determine the resident's mental status due to inattention, disorganized thinking and impaired decision making skills. The MDS also indicated she used a walker for mobility. She was receiving 81 mg of aspirin daily and Naproxen 250 mg as needed for pain. Both medications have side effects which increase the potential for bleeding. Nurses notes, of 12/3/11 at 10:20 a.m., indicated Resident B had been involved in an altercation with Resident C, and sustained a fall. The nurses notes, dated 12/4/11 at 12:29 p.m., regarding the incident indicated no staff had been present to witness the fall or to witness the resident being pushed. Resident B became less responsive, according to nurses notes of 12/5/11, at 10:33 a.m.,and was sent to the hospital. Hospital notes, dated 12/5/11, in			

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	the clinical record, indicated Resident B had been diagnosed by a CT (computed tomography) scan showing the presence of subdural, subarachnoid and intraventricular hemorrhage. The resident returned to the facility on 12/9/11 with comfort care orders. She expired 12/13/11. Review of the death certificate, obtained by the facility on 12/30/11, indicated the manner of death was homicide and the cause of death was failure to thrive with sequentially listed conditions leading to the cause of death being subdural and subarachnoid hematoma and a fall during an altercation. The description of how the injury occurred was listed as "decedent involved in altercation, fell and struck head." Prior to the fall of 12/3/11, a resident investigation questionnaire, dated 12/1/11 at 5:15 p.m., indicated Resident B had been found on the floor in the dining room. The fall had not been			

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	witnessed by staff members. The form indicated the resident had been observed prior to the fall walking around with her rolling walker too far in front of her. The form indicated another resident (not identified by facility staff) from the dementia unit saw Resident B fall, and the determination indicated the resident had lost her balance, sustaining the fall. According to nurses notes of 12/2/11 at 9:45 a.m., no injuries had been noted and the intervention was for the therapy department to assess the walker she was using. The physical therapy assessment, dated 12/2/11, indicated, "Resident has adequate & (and) appropriate assistive equipment." The three CNAs, who were working at the time of the incident on 12/3/11, were interviewed and indicated there was no staff person in the dining/activity room at the time of the incident. On 12/30/11 at 1:35 p.m., CNA #10			

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	indicated three CNA's and a Nurse were working on the Alzheimer's unit, at the time of the incident on 12/3/11. She indicated she and another CNA were on the back unit while the third CNA was assisting other residents on the front hall. CNA #10 indicated she heard yelling in the dining room, all three CNAs arrived in the dining room at the same time, and they found Resident B on the floor. CNA #10 indicated when she arrived in the dining/activity room, Resident B was on the floor and Resident C was standing up, swinging Resident B's walker at another resident (Resident D). CNA #10 indicated Resident C had told her she was "tired of (Resident B) following her around." CNA #10 indicated staff members have to "hurry" and get other residents away from Resident C when she is agitated. During an interview with CNA #11, on 12/30/11 at 2:30 p.m., she indicated she was working on the dementia unit, on 12/3/11, when the			

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	155159	A. BUILDING 00 B. WING	01/03/2012

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	altercation between Resident B and Resident C occurred. She indicated no staff member had been in the dining/activity area and she estimated 5 or 6 other residents had been present in the area at the time. CNA #11 indicated Resident B had a bump on her head and had "hurt" her back. CNA #12 was interviewed, on 12/30/11 at 2:10 p.m., and indicated she had been working on the Alzheimer's Unit on 12/3/11, when she heard yelling and something hit the floor in the dining/activity area. She indicated she went to the area and found Resident C swinging a walker at everyone nearby. She indicated Resident B was on the floor with an "egg-sized" bump on her head. She indicated Resident C was standing and several residents were in the area at the time but she was unable to remember who the residents were. On 12/30/11 at 1:50 p.m., two residents were observed sitting in			

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	the main dining/activity room on the Alzheimer's Unit. There was no staff present in the room. The residents were not interacting and were on opposite sides of the room. On 12/31/11 at 10:55 a.m., LPN #13 was interviewed and indicated she had been working on the Alzheimer's Unit on 12/3/11, the day of the altercation between Resident B and Resident C. She indicated she had been taking a cordless phone to a resident, when she heard yelling, went to the dining room and found Resident B lying flat on her back on the floor. LPN #13 indicated no staff member saw the incident but Resident F, who was fairly reliable, said Resident C pushed Resident B down. (The clinical record of Resident F was reviewed on 12/31/11 at 2:30 p.m. Resident F's BIMS (Brief Interview of Mental Status) score on the Quarterly MDS (Minimum Data Set) Assessment, dated 11/23/11, was 14, indicating the resident's cognition was intact.) On 12/31/11 at 11:30 a.m., CNA			

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	#14, indicated she had worked on the Alzheimer's unit for several years and, at the time of the incident between Resident C and B, staff were suppose to be with the residents in the dining/activity room but in practice, this was not always done because there was only one nurse and one aide covering the front halls. A facility inservice record, dated 12/5/11, provided by the Director of Nursing, indicated "A staff member is to be in DR (Dining Room) (Activity Room) @ (at) all times when there are 2 or more residents in the room." Review of the current census, provided by the Administrator, on 12/30/11 at 2:30 p.m., indicated 26 residents were currently living on the secure unit. The care plan aide sheets, provided by the DON, on 12/30/11 at 12:30 p.m., indicated 17 of the 26 were verbally abusive, 10 of the 26 were physically abusive or combative/hitting, 7 of 26 wandered.			

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	The most recent Annual Recertification and State Licensure Survey, dated 1/27/11, was reviewed on 12/30/11 at 3:00 p.m., and indicated the facility had been cited for failure to provide adequate supervision to prevent a fall with injury (fractured hip) at a harm level. The report indicated the incident had happened on the secured unit. The report also indicated a lack of supervision in the hallways, lounge area and dining room. The facility response to the 1/27/11, citation indicated, "The intent of this facility is to provide adequate supervision to prevent falls and to provide adequate supervision to prevent accidents." The plan of correction included measures to provide supervision, increased activities and cueing, plus daily monitoring for supervision and staffing inservices. The facility provided a plan for			

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	removal of the 12/1-31/11 Immediate Jeopardy on 12/30/11, which indicated: "Staff member will be in dining room/common area at all times. Schedule developed to cover each shift of the dining room/common area. Nurse Manager's office moved to dining room area. Staff in-service initiated on supervision and safety. This includes ensuring there is a staff member in the dining room/common area at all times on the Dementia Unit. Walkie Talkies purchased to enhance communication. Construction in process, once complete, the Nurses Station will be moved to area making dining room/common area visible." In addition, information regarding the activity program restructuring plan was provided on 12/31/11 at 3:00 p.m., by the Corporate Nurse. The revised program provided for alternating active and passive			

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	activities. An Immediate Jeopardy (IJ) was identified on 12/30/11 at 4:30 p.m. The Immediate Jeopardy began on 12/1/11 when the resident sustained a fall not witnessed by facility staff. The Administrator, Corporate Director of Operations, Clinical Care Specialist, Social Service Director and Director of Nursing were notified of the Immediate Jeopardy on 12/30/11 at 4:30 p.m., related to the lack of supervision to prevent accidents. The facility staff submitted a plan of action to remove the Immediate Jeopardy and the Immediate Jeopardy was removed on 12/31/11, when through interviews and observation of increased supervision, walkie talkie usage, and enhanced activities, it was determined the facility had implemented the plan of action to remove the Immediate Jeopardy and that the steps taken removed the immediacy of the problem. Even though the facility's corrective action removed			

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	the IJ, the facility remained out of compliance at a reduced scope and severity level of pattern with potential for more than minimal harm that is not immediate jeopardy. This federal tag relates to complaint IN00101632. 3.1-45(a)(2)			

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interviews, the facility failed to ensure complete and accurate records for 1 resident in a sample of 5 related to accuracy of medication administration, nursing notes and coroner's notification forms. (Resident B) Findings include: Review of the closed clinical record of Resident B, on 12/30/11 at 2:00 p.m., indicated she had been admitted to the facility on 3/11/09, with diagnoses including, but not limited to: dementia, hypertension and cardiac arrhythmia. A resident investigation questionnaire, dated 12/1/11 at	F0514	**514 Clinical Records** It is the practice of this provider to ensure the clinical records on each resident is maintained in accordance with accepted professional standards and practices that are complete: accurately documented; readily accessible; and systematically organized. The medical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident "B" no longer resides at the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** ·	01/27/2012

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	5:15 p.m., indicated Resident B had been found on the floor in the dining room. Nurses notes, dated 12/2/11 at 9:45 a.m., indicated the resident fell on 12/2/11 at 5:15 p.m. There was no corrective entry or late entry to indicated the correction to the nurses note. Nurses notes, dated 12/5/11 at 11:39 a.m., indicated the resident had been sent to the hospital by ambulance service due to a decline in condition following a fall. Nurses notes at 4:30 p.m., on 12/5/11, indicated the facility nurse had called the hospital for a report about Resident B's condition. The entry indicated the resident had been admitted to the hospital due to a subdural hematoma. Review of the Medication Administration Record (MAR) for December 5, 2011, for Resident B indicated the evening nurse had		Residents residing in the facility have the potential to be affected by the alleged deficient practice. · Licensed staff will be re-educated on appropriate documentation. This re-education will include review of documentation of medication and corrective entries. This in-service will be conducted by the Director of Nursing Services and/or designee by 1-24-12. · Licensed staff will be re-educated on Coroner's Notification and completion of the Coroner's Intake Record by the Director of Nursing Services and/or designee by 1-24-12. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Licensed staff will be re-educated on appropriate documentation and will include review of documentation of medication and corrective entries. This in-service will be conducted by the Director of Nursing Services and/or designee by 1-24-12. · Licensed staff will be re-educated on Coroner Notification and completion of the Coroner's Intake Record by the Director of Nursing Services and/or designee by 1-24-12. · Licensed staff will make corrections to mistaken entries by drawing one line through the mistaken entry with a date and initial. The desired entry will then be placed in the clinical record.	

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	administered Coreg 6.25 mg (a heart medication) and taken the resident's blood pressure at 8:00 p.m. The MAR was also initialed in the space for Pepcid at 8:00 p.m., indicating it had been given also. In addition to the medications being initialed as given, a bedtime snack was recorded as "accepted" and 240 cc of fluids with the 8:00 p.m., medications was recorded. The resident had been out of the building since prior to noon on 12/5/11. Review of the Protocol for Nursing Home Deaths, undated, and provided by the Corporate Nurse, on 12/31/11 at 3:30 p.m., indicated, in part..."4. If there is any question concerning whether the coroner should be contacted, call the coroner's representative and he/she will help make the decision. During normal work hours during the week, call the coroner's office at (phone number of coroner). During the weekends or after hours, call the county dispatcher at (phone		Nurse Managers will monitor this. · Residents out of facility will not have their medications signed. Nurse Managers will monitor this. · Licensed staff will contact the Director of Nursing Service and/or designee when a resident expires. The Director of Nursing Services and/or designee will determine when the Coroner's Office is to be contacted. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A "Medical Record Audit" CQI tool will be utilized weekly x 4, then monthly thereafter. · Data will be submitted to the CQI Committee for review and follow up. Non-compliance may result in disciplinary action up to and including termination. · The Director of Nursing and/or designee will be responsible for program compliance. **Compliance Date: 1-27-12.**	

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	number), and they will contact the deputy on duty. 5. a Coroner's Intake sheet should be filled out prior to contacting the coroner's office. This will then be faxed to the coroner's office at (phone number)." The form had not been filled out. During an interview with the Assistant Director of Nursing, on 12/31/11 at 10:45 a.m., she indicated she had not filled out the coroner's form or notified the coroner. She indicated she thought the previous Administrator had been the one to fill out the reporting form. During a telephone interview, on 12/31/11 at 11:15 a.m., with the previous Administrator (who had been the acting Administrator on 12/5/11), she was queried about filling out the form and sending it to the coroner's office, since the resident had expired following a head injury at the facility. She indicated she had not sent the form			

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	or notified the coroner and thought the nursing staff might have sent it. During an interview with the Director of Nursing, on 12/31/11 at 2:00 p.m., she indicated she had not filled out the reporting form and the coroner had called her following the resident's death on 12/13/11, to tell her the form should have been sent to the coroner's office. This federal tag relates to Complaint IN00101632. 3.1-50(a)(1) 3.1-50(a)(2)			